Illinois Department of Insurance
320 W. Washington Street
Springfield, IL 62767-0001

Preferred Provider Program Administrator Registration Form–PPA 1

Instructions:

Fee Requirement: Attach a check or money order payable to the Director of Insurance for $250.

Name of Firm		**Tax #**
Business Address (Number, Street)	**Phone No.**	**Fax No.**
City	**State**	**Zip Code**
Person responsible for submitting application		**Phone No.**

The following items must be filed with this registration and are, by reference, made a part of this registration form.

1. A general statement of the services to be offered in Illinois through the administrator's proposed plan of operations, including:

   (a) the method of marketing the program;
   (b) a geographic map of the area proposed to be served by the program with marked locations of medical providers;
   (c) a table showing breakdown of providers by type (i.e. hospital, primary care physician, specialist) by county;
   (d) a table showing breakdown of providers by type (i.e. hospital, primary care physician, specialist) by zip code;
   (e) an estimation of the number of beneficiaries projected to be served by the Administrator;
   (f) the names and addresses of the providers with whom the administrator has entered into agreements (provider directory);
   (g) a source for the beneficiary to contact regarding changes in the provider directory;
   (h) an organizational chart describing the relationship between the administrator, its parent organization and any affiliates, including the state of domicile and the primary business of each entity.

2. A list of the names, addresses, official positions and biographical affidavits **(form attached)** of the persons responsible for the conduct of the affairs of the administrator.

3. Sample copies of administrative agreements, payor agreements and provider agreements utilized by the administrator. If the terms and conditions in such agreements may vary, the filing of one complete sample agreement together with a description of all variable terms and conditions will satisfy this requirement.

4. A description of the standards by which the administrator assures that the health care services to be rendered under the preferred provider program are reasonably accessible and available to beneficiaries.

5. Copies of the preferred provider program disclosure statements required to be furnished to beneficiaries by 215 ILCS 5/370m, and correlary advertising material.

6. A description of programs for utilization review and timely resolution of questions, complaints and grievances.

7. Location of the administrative offices of the administrator located in this State and regular business hours during which offices are open.

8. A description of provider credentialing standards utilized by the administrator and a statement describing how the administrator intends to comply with 215 ILCS 5/370h.

9. A completed Bond/Fiduciary Account Requirement Form **(form attached)** or a written statement of exemption to this requirement;

10. The name, address and telephone number of the person within the administrator to whom all notices and renewal applications should be directed.

Declaration:

The undersigned declares that the statements made in this application are true, correct and complete to the best of his/her knowledge and belief.

Signature	**Date**
Print Name and Title	**Phone**

Important Notice: Under the Illinois Revised Statutes' Insurance Laws, disclosure of this information is **voluntary**; however, failure to comply may result in this form not being processed. This form has been approved by the Forms Management Center.